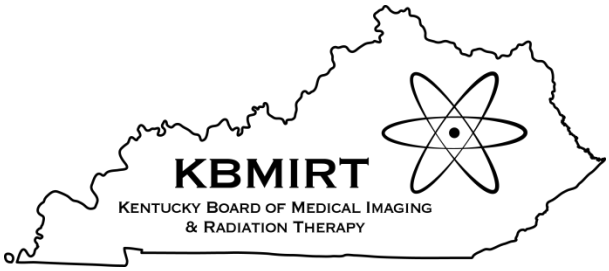

Kentucky Board of Medical Imaging and Radiation Therapy

125 Holmes Street, Suite 320
Frankfort, KY 40601
Phone: (502)782-5687

Scholarship Application- Medical Imaging and Radiation Therapy Scholarship and Continuing Education Fund

For Office Use Only:

Applicant Information

Application for (select one): ☐ **Entry Level Scholarship** ☐ **Advanced Education Scholarship**

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Social Security Number (last 4 digits): _____ Date of Birth: _____
Month *Day* *Year*

Eligibility

Are you a resident of Kentucky? ☐ Yes ☐ No

Are you currently licensed by KBMIRT? ☐ Yes ☐ No If yes, license number: _____

Employment Information

Place of Employment: _____

Business Address: _____
Street Address

_____
City *State* *Zip Code*

Work Telephone Number: _____ Work Email: _____

Start Date: _____ Title: _____

☐ **I am not currently employed as a medical imaging technologist or radiation therapist.**

List any previous work experience in healthcare (paid or volunteer).

Dates (MM/YY-MM/YY):	Facility:	Job Title or Major Duty:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education Information

Type of Program: ☐ Associates ☐ Bachelors ☐ Masters ☐ PhD ☐ Limited X-ray ☐ Structured Education

Please provide information about the educational program where you have been accepted to complete your medical imaging or radiation therapy education.

Name of Educational Institution: _____

Name of Program: _____

Address: _____

Name of Program Administrator: _____

Telephone Number: _____ Email Address: _____

Is the program accredited? ☐ Yes ☐ No If yes, by which accrediting organization?_____

Anticipated Date of Completion: _____

Disclaimer and Signature

All applicants please read and sign/date the statement below. All applications will be null and void unless properly signed and dated.

I hereby submit this application and supporting documents and attest to the authenticity and accuracy of the application and all information contained herein. I further understand that if any information contained in this application or supporting documents submitted on my behalf, is determined to be false or misleading, this may be cause for denial, revocation or suspension of any license pursuant to this application and criminal prosecution and punishment. I understand that if I do not meet the obligation of this program, I will be required to repay the scholarship funds received plus accrued interest. I understand that I will be required to sign a promissory note and contract to receive the scholarship funds.

Signature of Applicant: _____ Date: _____

Deadline for Submission:

By April 1, mail the completed application to:

Medical Imaging and Radiation Therapy Scholarship and Continuing Education Fund
125 Holmes Street, Suite 320
Frankfort, Kentucky 40601

Application forms that are not postmarked by the April 1 deadline date will be considered ineligible.